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FOR ACTION

COUNTRY PROGRAMME STRATEGY NOTE**

Lesotho

SUMMARY

The Executive Director presents the country programme strategy note for Lesotho for a programme of cooperation for the period 1997 to 2001.

Up to 60 per cent of the population of Lesotho live in absolute poverty, caused by low agricultural productivity and unemployment. Many men migrate to work in the gold mines of South Africa and women are left with heavy responsibilities and few rights. There are significant labour demands on children, who suffer from poor nutrition and lack of access to education. While service delivery in health has achieved some short-term gains, there is a need to decentralize management, improve cross-sectoral coordination and involve communities in monitoring and solving child survival and development efforts.

The proposed programme of cooperation aims to increase broad-based participation through capacity-building and empowerment. Communities will be assisted to become more involved in primary health care, the organization of basic education and primary environment care. The main vehicle for this will be community health and education committees, supported by the district-level administration. The strategy will also include advocacy for and monitoring of the rights of children and women, based on proposed revisions to legislation, improved use of information at community and district levels, and policy and budgetary reform.

* E/ICEF/1996/2.

** An addendum to the present report containing the final country programme recommendation will be submitted to the Executive Board for approval at its third regular session of 1996.

THE SITUATION OF CHILDREN AND WOMEN

1. Since 1973, Lesotho has not produced sufficient food to feed its 2 million inhabitants. Up to 60 per cent of the population live in absolute poverty due to low agricultural productivity and unemployment. Eighty per cent of the population live in rural villages, but urban populations are growing at a rate of up to 10 per cent per year. Fifty-one per cent of households are headed or managed by women, many of whose husbands work in the gold mines of South Africa.

2. Progress towards the mid-decade goals is mixed. The national infant mortality rate (IMR) has declined to 85 per 1,000 live births, but in the highlands it is still 99 per 1,000 live births, while in the lowlands, where 60 per cent of the population live and health services are accessible, it is 76 per 1,000 live births. Between 1992 and 1994, stunting increased from 33 to 42 per cent, moderate malnutrition increased from 15 to 18 per cent and severe malnutrition increased from 2.4 to 5.7 per cent. While full immunization coverage rose to 71 per cent in 1993, there is still a high incidence and poor treatment of acute respiratory infections and diarrhoea. The oral rehydration salts (ORS) usage rate fell from 60 per cent in 1991 to 42 per cent in 1993, and ORS is not available in 52 per cent of the health centres. The ability of health personnel to communicate with parents on preventive measures is poor. The lack of personal hygiene is exacerbated by low access to safe water: 42 per cent in rural areas and 45 per cent in urban areas. Access to safe means of excreta disposal is 65 per cent in rural areas and 63 per cent in urban areas. The current drought has reduced the availability of water by 15 per cent.

3. Seventy per cent of women are literate as compared to 54 per cent of men. The primary school enrolment rate is 68 per cent for boys and 85 per cent for girls, but the completion rate is only 12 per cent for boys and 20 per cent for girls. Boys' enrolment and completion rates are constrained by their traditional full-time work as herdboys. Girls' completion rates are influenced by domestic work and early marriage. The quality of teaching is poor, with 21 per cent of teachers not qualified. School fees are also considered high by rural families.

4. The maternal mortality rate (MMR) is 269 per 100,000 live births largely because 50 per cent of deliveries take place at home and only 20 per cent of them are assisted by trained personnel. Only 54 per cent of pregnant women have access to antenatal care. Thirty-six per cent of women of child-bearing age have goitre. Sexually transmitted diseases and HIV/AIDS are becoming serious problems. Injuries are frequent due to a high rate of violence and alcoholism. Although the Convention on the Elimination of All Forms of Discrimination Against Women has been ratified, women face legal barriers and discriminatory traditional practices. Currently, women cannot inherit land, establish a business or obtain credit without their husbands' consent. Under the law, women are minors.

LESSONS LEARNED FROM PAST COOPERATION

5. To achieve greater impact, there is a need to coordinate the planning and implementation of the projects that UNICEF supports in health, nutrition, water supply, sanitation, household food security, income-generating activities for women, early childhood and youth development, and primary education. Supply assistance also needs to be streamlined to avoid duplication and increase efficiency. A vertical, top-down service delivery strategy has been successful in the short term, but is not sustainable and has led to bureaucratic

inefficiencies. Local institutions need to be strengthened to improve the quality of services and promote management through participatory processes.

6. Statistics are only available for the national level. Lesotho needs to develop a multilevel planning and management information system based on information at the community level. The support of district personnel will be vital in the effective processing, updating and use of information on the situation of all communities.

PROPOSED COUNTRY PROGRAMME STRATEGY

7. The aim of the programme of cooperation is to mobilize broad-based participation in accelerating progress towards sustainable improvements in children's health and well-being. Specific objectives include (a) to reduce IMR from 85 to 50 per 1,000 live births; (b) to reduce MMR from 269 to 65 per 100,000 live births; (c) to reduce severe and moderate malnutrition among children under five years of age from 5.7 and 18 per cent, respectively, to 2 per cent and 9 per cent; (d) to increase the net primary school enrolment rate from 71 to 85 per cent; (e) to increase the primary school completion rate from 30 to 50 per cent; (f) to increase access to latrines from 35 to 65 per cent in urban areas, to rural water supply from 42 to 81 per cent and to urban water supply from 46 to 92 per cent; and (g) to reduce women's workload and time in collecting fuel by 75 per cent. The key strategy will be capacity-building for community empowerment through gender-sensitivity and government-community co-management, with a particular emphasis on legal, informational and policy approaches. Capacity-building will be based on integrated urban and rural assistance packages by all donor agencies, coordinated by the Government and planned in a participatory manner. The constituency plan of action planning process, which has been initiated with UNICEF support, will form the basis for rapidly scaled-up community empowerment in development. The strategy also will include advocacy for the rights of children and women. Service delivery will continue in three interrelated components: basic education and training; primary health care (PHC); and nutrition.

8. The objective in basic education will be to expand coverage and improve quality. In Lesotho, the Ministry of Education and the churches own the primary schools, but community leaders are not involved in the management of education because they lack knowledge and skills. The strategy will be to assist newly established district education officers to provide assistance and training so that communities can establish school management committees and community education committees for community schools supervised by an existing primary school. The quality of teaching will be improved by increased supervision, more detailed learning plans and the use of the mass media to support both teachers and pupils. Teacher training will be improved through the introduction of student-centred, participatory methods involving community resources. Curriculum reforms will focus on literacy, oral expression, numeracy and problem-solving required for survival. Community schools will hold non-formal classes for herd-boys and other school drop-outs. There will also be support for attempts to integrate children with disabilities in the primary school system. Support will be provided for strengthening the education planning and management information system at community, school and district levels.

9. Similar strategies will be followed for early childhood development, which is home- and community-based in Lesotho and receives no assistance from the Government or non-governmental organizations (NGOs). The strategy will be to support women community leaders by training them in nutrition, health, psycho-social development, environmental issues and improved child-care practices.

10. In the health sector, the strategy will be to support national health and nutrition policies which are based on PHC, with an emphasis on Government-community partnership in co-managing decentralized basic health services, the equitable distribution of quality and gender-sensitive health services, and the need for linkages with other sectors. Village and urban development councils will form village health committees where none exist and mobilize technical support and training for community participation in surveys, analysis, project formulation and implementation. Health centres will support greater collaboration among community health workers (CHWs), traditional birth attendants and traditional health practitioners. Village health committees will also monitor the quality of services provided by health centre staff.

11. The quality of preventive, promotive and curative services will be improved through the planning of on-the-job and task-related training of health workers. There will be an emphasis on assessing post-training performance, especially with respect to vaccination coverage; the use of oral rehydration therapy; case management of pneumonia, tuberculosis and diarrhoea; breast-feeding; preventing disability through supplementation for iodine and vitamin A deficiency; women's and adolescents' reproductive health; HIV/AIDS prevention; and family violence mitigation.

12. The nutrition strategy will change from a top-down approach to an integrated, community-based intersectoral approach involving cooperation with relevant agencies at the district level. More appropriate practical training activities will be introduced to enable community leaders and CHWs to monitor the growth of children and to respond correctly to problems of malnutrition.

13. The strategy for primary environmental care will focus on household food security, rural and peri-urban water supply and sanitation, and household energy security. Priority will be given to environmentally-degraded rural and peri-urban communities with high levels of poverty and malnutrition. Through advocacy and training, communities will be encouraged to increase the range of crops grown on home gardens and raise small animals for home consumption. There will be greater emphasis on community involvement in the management and maintenance of rural and peri-urban water supply, especially through the promotion of water harvesting and conservation techniques. In rural and peri-urban sanitation, which aims to double access to safe means of excreta disposal within five years, there will be stronger linkages with PHC, nutrition and education. Household energy security activities will introduce fuel efficient stoves and alternative sources of energy for cooking and heating to significantly reduce the burdens of rural women. Throughout the programme, there will be an emphasis on the convergence of services and networking among NGOs and interested donors.

14. Programme development aims to strengthen the legal framework for the rights of children and women. The Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women have been ratified by the Government. Hence, advocacy will be based on an analysis of national laws and regulations and will recommend changes to those that do not conform with the provision of the Conventions. In addition, training will be provided to rural and urban communities in the rights' approach to the prevention of child abuse and neglect, violence to women and juvenile delinquency.

15. Programme development also will include assistance to policy and programme formulation based on decentralized planning, programming and budgeting. The strategy will be to improve procedures at the district level for information-sharing, planning and intersectoral linkages within the framework of

an integrated programme package. The strategy will be to advocate for the decentralization of resources for development projects to enable the managers at the district level to make decisions on the allocation of resources based on priorities agreed with communities.

16. The provisions of both Conventions will be used as standards against which to monitor programmes implemented by government agencies, church institutions and NGOs. In response to the need to set up a multilevel planning and management information system based on information at the community level, profiles of all 8,500 villages and urban communities in the country will be established and will include information on basic indicators and the projects that are being implemented. This will call for training and technical assistance in the collection, analysis and use of information for problem-solving at district and community levels.

17. The World Bank has allocated $55 million per year to the Lesotho Highlands Water Revenue Development Fund, much of which is earmarked for local development projects. The Government/UNICEF approach to capacity-building for community empowerment will enable communities to benefit from this fund and to manage their own projects.

ESTIMATED PROGRAMME BUDGET

Estimated programme cooperation, 1997-2001 a/
(In thousands of United States dollars)

	General resources	Supplementary funds	Total
Basic education and training	1 500	4 500	6 000
Primary health care and nutrition	1 500	4 500	6 000
Primary environmental care	750	3 250	4 000
Programme development	1 250	2 750	4 000
Total	5 000	15 000	20 000

a/ These are indicative figures only which are subject to change once aggregate financial data are finalized.